AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

July 11, 2012

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These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

Grant and Demonstration Announcements

Affordable Care Act - Maternal, Infant and Early Childhood Visiting Program, §2951. Announced July 9, 2012. Funding is available to applicants that wish to build on their home visiting programs. States and territories that have not received an FY 2011 Competitive Expansion Grant or Development Grant are eligible to apply. Grants provide funding to applicants that can demonstrate the ability to expand or enhance their evidence based home programs. Applicants may address the following areas of emphasis: improvements in maternal, child, and family health; implementation and expansion of evidence-based home visiting programs; development of statewide or multi-state home visiting programs; development of comprehensive early childhood systems from prenatal to age eight; outreach to high-risk and hard-to-engage populations; development of family-centered approach to home-visiting; outreach to families in rural or frontier areas; and development of fiscal strategies to improve program sustainability. $12M in 4-8 awards is available. Applications are due August 8, 2012.

The announcement can be viewed at: HRSA

Health Care Surveillance/Health Statistics - Surveillance Program Announcement: Behavioral Risk Factor Surveillance System (BRFSS), §4002. Announced July 3, 2012. Funding is available to current grantees to measure the behavioral public health impact through surveillance, assessment and evaluation efforts. Eligible applicants are entities currently funded

under the CDC's Behavioral Risk Factor Surveillance System. Supplemental funding will allow BRFSS to add key questions to the 2013 BRFSS survey questionnaire which will allow precise estimates from participating states and territories and many localities (counties, cities, MSAs). These estimates will be tracked over a 12 month time period to assess the impact of the ACA on health insurance coverage opportunities and enrollment, access to health care services, use of preventive health services, and other factors. $3.6M in 53 awards is available.

Applications are due August 2, 2012.
The announcement can be viewed at: Grants.gov

Strong Start for Mothers and Newborns, §3021. Originally announced February 8, 2012. This initiative will test three different approaches to providing enhanced prenatal care delivery and to help reduce the increasing number of preterm births. CMS will test new care and payment models that have the potential to improve prenatal outcomes for women enrolled in Medicaid who are at high-risk for adverse pregnancy outcomes. Funding is available to State Medicaid agencies, providers of obstetric care, managed care organizations in partnership with providers, and conveners in partnership with other applicants. $41.4M total is available for this initiative. The number of awards will depend on the number of women that applicants propose to enroll in each of the three models. The Innovation Center intends to fund the cost of care for 30,000 women in each of the three options over three years.

7/3/12 CMS announced that the deadline has been extended and applications for the Strong Start demonstration are now **due August 9, 2012** (not June 13, 2012 as originally posted).

For more information, visit: http://innovations.cms.gov/initiatives/Strong-Start/index.html
For the amended funding announcement, visit: CMS

Grant Activity

July 6, 2012 Massachusetts submitted an application to CCIIO for an Affordable Care Act Consumer Assistance Programs (CAP) grant in partnership with Health Care for All (HCFA) under §1002 of the ACA. Funding is available to states for the establishment or support of independent offices for health insurance CAP programs that help consumers who have questions or concerns regarding their health insurance. Using these funds, CAP grantees will: Help consumers enroll in health coverage, including group health plans and other health insurance coverage; help consumers file complaints and appeals against health plans; educate consumers about their rights and empower them to take action; and track consumer complaints to help identify problems and strengthen enforcement.

In 2010 HHS distributed nearly $30 million in CAP grants to help states and territories establish or enhance activities to educate consumers about their health coverage options and to ensure consumer access to their rights under state and federal law, including the ACA. In October 2010, Massachusetts was awarded a one-year $742,888 CAP grant to be used in partnership with HCFA to provide consumers statewide with assistance and up-to-date information about health care coverage options and issues (in several languages) as they navigate the health insurance system and to assist consumers with health insurance appeals

For more information on states' first CAP grant cycle programs, including the Massachusetts' CAP program, visit: Healthcare.gov
For more information on CAP Grants visit: Information
The project narrative can be viewed on our website under the Grants and Demonstrations section at: Mass.Gov

Guidance

7/10/12 CMS issued the first two letters in a series of communications that provides states with guidance on designing and implementing care delivery and payment reforms that improve health, improve care, and reduce costs within Medicaid programs. The State Medicaid Director (SMD) letters describe the policy considerations for creating "Integrated Care Models" (ICMs), which could include (but are not limited to) medical/health homes, Accountable Care Organizations (ACOs), ACO-like models, and other arrangements that emphasize person-centered, continuous, coordinated, and comprehensive care.

Read the bulletin at: Medicaid

The first SMD Letter, Integrated Care Models, is the first in a series that will describe policy considerations for creating integrated care models. According to CMS, the communications are intended to strengthen the agency's collaborations with states to facilitate achieving better care, better health, and reduced expenditures in Medicaid programs. In this letter, CMS states that ICMs could include (but are not limited to) medical/health homes, Accountable Care Organizations (ACO), ACO-like models, and other arrangements that emphasize person-centered, continuous, coordinated, and comprehensive care. The agency also states that such models support value-driven strategies to ensure that Medicaid reaches its fullest potential as a high performing health system and aligns with promising delivery system and payment reforms underway in the private and public sectors.

Read the first letter at: Medicaid

The second SMD Letter, **Policy Considerations for Integrated Care Models**, describes flexibility in the Medicaid statute that supports delivery system and payment reform in fee-for-service systems. The letter provides guidance to states on designing and implementing care delivery and payment reforms that improve health, improve care, and reduce costs within Medicaid programs. According to CMS, future communications will include methodologies for shared savings arrangements, a quality and cost measures framework, achieving results through managed care contracts, and guidance on alignment with other federal initiatives.

Read the second letter at: Medicaid

7/11/12 CMS published a proposed ACA-related regulation called "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Bad Debt Reductions for all Medicare Providers." The proposed rule implements portions of ACA §3401 and §3014.

The rule proposes to update and make revisions to the End-Stage Renal Disease (ESRD) prospective payment system (PPS) for calendar year (CY) 2013. The rule also proposes to set forth requirements for the ESRD quality incentive program (QIP), including for payment year (PY) 2015 and beyond. The proposed rule will implement changes to bad debt reimbursement for all Medicare providers, suppliers, and other entities eligible to receive bad debt. Comments are due August 31, 2012.

Read the press release at: CMS
Read the regulation at: http://www.gpo.gov/fdsys/pkg/FR-2012-07-11/pdf/2012-16566.pdf

7/2/12 CMS/CCIIO issued a notice/ information collection request notice under the Paperwork Reduction Act which includes the following four ACA-related topics: 1) Initial Plan Data Collection to Support Qualified Health Plan Certification and Other Financial

Management and Exchange Operations (as required by the Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers Final Rule); 2) Data Collection to Support Eligibility Determinations and Enrollment for Employees in the Small Business Health Operations Program (§1311(b)(1)(B)); 3) Data Collection to Support Eligibility Determinations and Enrollment for Small Businesses in the Small Business Health Options Program (§1311(b)(1)(B)) and 4) Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid and CHIP Agencies (§1413).
Comments are due September 4, 2012.

Read the notice (published on July 6, 2012) at: GPO.Gov

7/2/12 CCIIO/ CMS issued guidance called "Essential Health Benefits: List of the Largest Three Small Group Products by State." As required by the ACA, beginning in 2014, all plans sold in the exchanges and through the small/non-group market must offer a set of essential health benefits (§1302), a package of medical services and treatments which includes ambulatory and emergency care, maternity care, prescription drugs and other comprehensive health care services in ten categories.

This document provides information to facilitate states' selection of the benchmark plans that would serve as the reference plans for the essential health benefits (EHB). HHS has previously issued some guidance on EHB. This information is provided as an update to the agency's prior publication "Essential Health Benefits: Illustrative List of the Largest Three Small Group Products by State" which provides information about the kinds of benchmark plans that states could consider when formulating their EHB packages. This publication was released on January 25, 2012, and complements the bulletin on HHS' intended benchmark approach to defining EHB was published on December 16, 2011.

Using data from HealthCare.gov, the document provides an updated list of the three largest small group insurance products ranked by enrollment for each state. In addition, CCIIO provides lists of the three largest nationally available Federal Employee Health Benefit Program (FEHBP) plans, a benchmark option outlined in the bulletin. The agency also provides the single largest Federal Employees dental and vision plans based on enrollment.

Read the document entitled, "Essential Health Benefits: List of the Largest Three Small Group Products by State" at: http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf.pdf

Prior guidance can be viewed at www.healthcare.gov

News

7/9/12 CMS announced that under the Medicare Shared Savings Program (Shared Savings Program), a program authorized by §3022 of the ACA that helps to facilitate coordination among providers to improve the quality of care for Medicare beneficiaries, 89 Accountable Care Organizations (ACOs) have entered into agreements with CMS, as of July 1, 2012. The ACOs serve 1.2 million people with Medicare in 40 states and Washington D.C., taking responsibility for the quality of care provided to Medicare beneficiaries in return for the opportunity to share in savings realized through improved care.

ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve to helps

ensure that patients, especially the chronically ill, get appropriate care, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program. Medicare offers several ACO programs, including: 1) Medicare Shared Savings Program (for fee-for-service beneficiaries), 2) Advance Payment Model (for certain eligible providers already in or interested in the Medicare Shared Savings Program) and 3) Pioneer ACO Model (Health care organizations and providers already experienced in coordinating care for patients across care settings).

The additional 89 ACOs announced bring the total number of organizations participating in Medicare shared savings initiatives to 154, including the 32 ACOs participating in the testing of the Pioneer ACO Model by CMS's Center for Medicare and Medicaid Innovation (Innovation Center) announced in December 2011, and six Physician Group Practice Transition Demonstration organizations that started in January 2011. In all, as of July 1, more than 2.4 million beneficiaries are receiving care from providers participating in Medicare shared savings initiatives.

Learn more about the Pioneer Model at: Innovations
Learn more about the Physician Group Practice Transition Demonstration at: CMS

The selected ACOs include more than 10,000 physicians, 10 hospitals, and 13 smaller physician-driven organizations in both urban and rural areas. Their models for coordinating care and improving quality vary in response to the needs of the beneficiaries in the areas they are serving. CMS is reviewing more than 150 applications from ACOs seeking to enter the program in July. To ensure that savings are achieved through improving and providing care that is appropriate, safe, and timely, an ACO must meet strict quality standards. For 2012, CMS has established 33 quality measures relating to care coordination and patient safety, appropriate use of preventive health services, improved care for at-risk populations, and the patient and caregiver experience of care.

Beginning this year, new ACO applications will be accepted annually. The application period for organizations that wish to participate in the MSSP beginning in January 2013 is from August 1, 2012 through September 6, 2012.

More information, including application requirements, is available at: CMS
Learn more about the 89 ACOs announced at: CMS

7/9/12 The Advisory Board Company published a report called "Where Each State Stands on ACA's Medicaid Expansion: A Roundup of What Each State's Leadership Has Said About Their Medicaid Plans." Since the Supreme Court's ruling on the ACA allows states to opt out of the law's Medicaid expansion provision (§2001), each state's decision to participate rests with its governors and state leaders. The report, which is largely based on lawmakers' statements, press releases, and media coverage, includes a listing of where each state currently stands on the expansion. At least five governors (Florida, Louisiana, Mississippi, South Carolina and Texas) are on record as opposing the expansion. Five states are leaning toward not participating; three states are leaning toward participating; ten states (including Massachusetts) and the District of Columbia are planning to participate; and at least 26 states have suggested they are undecided.

The Advisory Board Company is a global research, consulting, and technology firm partnering with 125,000 leaders in 3,200 organizations across health care and higher education.

Read the report, which has been updated several times since it was first published, at: Advisory

7/6/12 Urban Affairs published a study called "Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would not Be Eligible for Medicaid?" The Supreme Court ruling on the Affordable Care Act made the expansion of Medicaid coverage to nonelderly adults with incomes below 133% FPL (138% with a 5% disregard) optional for states, allowing states to maintain their current programs without losing all of their Medicaid funding.

The ACA expanded Medicaid eligibility to everyone up to 133% FPL (§2001) and provides subsidies and federal tax credits to buy private insurance to people with incomes between 100% FPL and 400% FPL (§1401). If a state does not implement the expansion, some people who would have received Medicaid could instead receive federal tax credits and other subsidies, but premium and cost-sharing requirements would be higher than they would be under Medicaid. Federal tax credits and subsidies, however, would not be available for people with incomes below 100% FPL since they are available only for those with incomes between 100% FPL and 400% FPL. As a result, the uninsured above 100% FPL could receive help, but those below 100% FPL may not. For example, in Florida parents are eligible for Medicaid up to 58% FPL. If Florida opts out of the ACA expansion, parents between 58% FPL and 100% will be ineligible for Medicaid (and federal tax credits), while parents above 100% FPL will be eligible for federal tax credits. Most other residents (besides pregnant women, who are eligible up to 185% FPL in Florida, and other categories such as the elderly and disabled, who are subject to different rules under the ACA) will not be eligible for aid unless they have incomes above 100% FPL (and are eligible for federal tax credits).

In the analysis, Urban Institute researchers estimate the number of uninsured Americans in each state who could be eligible for Medicaid if all states expand Medicaid coverage. Of 22.3 million uninsured Americans who could be potentially eligible for Medicaid under the ACA, 67% (15.1 million) are adults not currently eligible for Medicaid. Of this group, 11.5 million have incomes below 100% FPL and would not qualify for any other subsidized coverage. According to the brief, the states with the biggest potential gaps are California, Texas and Florida.

Read the brief at: Urban.Org

EOHHS News

Request for Responses from Integrated Care Organizations
On June 19, the Executive Office of Health and Human Services (EOHHS) issued a Request for Responses (RFR) to solicit proposals from Integrated Care Organizations (ICOs) to participate in the Duals Demonstration program. The purpose of this Demonstration is to improve quality of care and reduce health disparities, improve health and functional outcomes, and contain costs for dual eligibles. Under this program the selected ICOs will be accountable for the delivery and management of all covered medical, behavioral health, and long-term services and supports for their enrollees. The RFR and related appendices are posted at: www.mass.gov/masshealth/duals and on the state procurement website Comm-PASS (www.comm-pass.com) under the Document Number 12CBEHSDUALSICORFR.
Responses to the RFR will be due to EOHHS by 4:00 PM (EDT), July 30, 2012.

Read more at: Mass.Gov

Request for Responses for Consumer Consultants
On June 19, MassHealth issued a Request for Responses (RFR) from Integrated Care Organizations (ICOs) to participate in the Demonstration. EOHHS is issuing a separate RFR seeking the advice of up to six MassHealth members who are Consumers of medical services, behavioral health services and/or LTSS ("Consumer Consultants"). The selected Consumer

Consultants will form a paid advisory subcommittee that shares its thoughts and expertise with EOHHS throughout the process of reviewing and evaluating the RFR responses that EOHHS receives from organizations seeking to be ICOs.

Details about the qualifications, responsibilities, and requirements for Consumer Consultants are provided in the RFR, along with information on how individuals can submit responses. Individuals who are interested in serving as Consumer Consultants are asked to submit a short written statement, two references, and some other information to EOHHS. **The deadline for responses is July 20, 2012 at 4 PM.** The RFR is available on the state procurement website Comm-PASS (www.comm-pass.com) as Document Number 13CBEHSCONSUMERCONSULTANTRFR and at http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/120705-duals-consumer-consultant.pdf on the Integrating Medicare and Medicaid for Dual Eligibles website under Related Information.

Upcoming Events

Integrating Medicare and Medicaid for Dual Eligible Individuals Open Meeting
July 27, 2012, 10:00 AM - 12:00 PM
State Transportation Building, Conference Rooms 1, 2, & 3, Second Floor, 10 Park Plaza, Boston, MA

The purpose of this meeting will be to give an update on the Demonstration, and to focus on consumer issues.

Reasonable accommodations will be made for participants who need assistance. Please send your request for accommodations to Donna Kymalainen at Donna.Kymalainen@state.ma.us

Bookmark the **Massachusetts National Health Care Reform website** at: http://mass.gov/national health reform to read updates on ACA implementation in Massachusetts.

Remember to check http://mass.gov/masshealth/duals for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.